Appendix F

2002-2010
Texas State Health Plan

STATEWIDE HEALTH COORDINATING COUNCIL RESPONSE TO PUBLIC COMMENT

I. Texas Higher Education Coordinating Board

Comments:

Recommends the following revisions to the Nursing Workforce Recommendations:

2. The Legislature should continue to support the Nursing Innovation Grant Program funded by tobacco earnings from the Permanent Fund for Higher Education Nursing, Allied Health, and Other Health-Related Programs and administered by the Texas Higher Education Coordinating Board.

SHCC Response: Changed as recommended.

4. The Legislature should provide institutions with Special Item funding to support enrollment increases in nursing programs and stimulate graduate programs that prepare nursing faculty, and establish procedures that would confirm that these special allocations for nursing programs are spent for these purposes.

SHCC Response: Changed as recommended.

8. The Texas Higher Education Coordinating Board and the Texas Board of Nurse Examiners should encourage institutions to use technology, preceptors, simulation, etc., to maximize the use of existing and new faculty, while ensuring quality outcomes and increasing student enrollments.

SHCC Response: Changed as recommended.

Recommends the following revisions to the Primary Care Recommendations:

Add a new recommendation regarding pharmacy education; it could be placed between current recommendations 6 and 7.

The Legislature should provide Special Item funding to support enrollment increases at the state's pharmacy schools to help relieve the current shortage of pharmacists in the state.

SHCC Response: Recommendation added.

6. The Legislature should increase funding levels for the Physician Education Loan Repayment Program by mandating that all Texas medical schools that receive state funds participate in the "two percent set aside."

SHCC Response: Changed as recommended.

II. Texas Hospital Association-Rural Hospital Division

Comments:

1. Primary care physicians...They can't find enough of them to meet the needs. Internal medicine is becoming scarcer, and OB/GYNs scarcer still, unless one already is in practice in the rural community seeking to recruit another. This makes sense, when you consider the scope and 24 hour responsibility of an OB physician's practice.

SHCC Response: No action required. Current document supports comment. Texas followed the lead of other states and passed tort reform in the 78th Regular Legislative Session.

2. Nursing is still an issue, although for now most rural hospitals have increased salaries, benefits, and improved working conditions to be competitive with urban areas. Urban areas keep upping the ante. The problem will become exacerbated as more nurses retire in years to come, and as the nursing instructors continue to age and retire. Then, we will have the issue flare up badly again.

SHCC Response: No action required. Current document supports comment.

3. Next hot area: CRNA's....very hard to find in rural areas, and if they can be found, they are becoming increasingly unaffordable.

SHCC Response: No action required. Current document supports comment.

4. Radiology techs, and especially ultrasonagraphers, very hard to find in some rural areas.

SHCC Response: No action required. Current document supports comment.

5. Pharmacists are also becoming harder to find, and as rural pharmacists retire, the "sticker-shock" of replacing them with staff requiring retail pharmacist's salaries (now in the triple digits) is tough on rural hospitals. (Some rural CEOs still do not make triple digit salaries!)

SHCC Response: No action required. Current document supports comment.

6. Mental health workers....any category, are hard to recruit/retain in rural areas.

SHCC Response: No action required. Current document supports comment.

7. Dentist and dental technicians are in short supply in rural areas, which in many parts of the state, lack dental staff to maintain oral health.

SHCC Response: No action required. Current document supports comment.

III. Consortium of Texas Certified Nurse Midwives

Comments:

The Consortium of Texas Certified Nurse Midwives (CTCNM) fully supports the focus of the 2005-2010 Texas State Health Plan on having competent health professionals strategically placed in the health care delivery system. We are pleased that under the Nursing Workforce Recommendations, an increase in funding levels to nursing programs is included. Under the Primary Care Recommendations, you have 5 recommendations, which address financial support for medical education programs and their students. The importance of physician providers to a health care delivery system is universally understood.

CTCNM urges your consideration of the contribution of certified nurse midwives to our health care system. Nurse midwives have demonstrated that they are competent health professionals who can safely provide many of the same services as OB/GYN physicians. In health settings, they have improved access to care by increasing the provider pool and by freeing physicians to focus on high-risk patients. As the enclosure demonstrates, numerous studies on nurse-midwifery care consistently report good outcomes with associated cost savings. In addition, nurse-midwifery educational programs are shorter and less expensive than medical educational programs.

Unfortunately, within the last year, two nurse-midwifery educational programs have stopped admitting new students. Currently there is only one educational program remaining within the state. Given the proven value of this group of professionals, we urge you to expand your recommendations to include increasing funding specifically for educational settings that provide nurse midwifery educational programs.

SHCC Response: The SHCC recognizes the challenges that the projected increase in birth rates will present for the Texas population. Staff suggests adding an additional recommendation under "Nursing Recommendations" as follows: *The Legislature and the Texas Higher Education Coordinating Board should study avenues to expand nurse-midwifery educational programs.*

IV. Parkland Health Care System

Comments:

Thanks so much for allowing a comment period on the 2005-2010 State Health Plan. Parkland would like to make the following comments:

The Higher Education Coordinating Board is currently conducting a study of the state's support of Graduate Medical Education. There are two interim committees, one in each chamber, that is reviewing the consequences of the Legislature's elimination of GME funding in the 78th Session. Preliminary reports indicate that there is a $380 million shortfall for 67% of the residents in teaching hospitals. It is strongly recommended that the work of the HECB and the findings of the two legislative committees be given high priority by the 79th Legislature. The retention of residency slots assure that doctors have a tendency to stay in the state that helps fund residencies. Current shortages of doctors in underserved areas and the looming shortfall of doctors in urban and rural areas must be addressed in the immediate future.

SHCC Response: Recommendations included within *the 2005-2010 Texas State Health Plan* have been coordinated with the Texas Higher Education Coordinating Board's study and their subsequent recommendations. No additional action required.

V. Texas Society for Respiratory Care

Comments:

The TSRC is concerned that the Draft document does not recognize, nor include data and information, on the profession of respiratory care even though our profession has an integral and growing role in providing non acute care services to the people of Texas, such as asthma disease management and smoking cessation counselors, two important public health issues facing all states.

The Texas Society for Respiratory Care respectfully requests the final version of the 2005-2010 Texas State Health Plan include information and data for the respiratory care practitioner in sections:

Chapter 2, "Status of the Health Workforce in TX under the Allied Health Profession".

Appendix B: Primary Care White Papers

Appendix C: Health Workforce Data.

SHCC Response: The SHCC recognizes the important role that Respiratory Therapists serve in the delivery of health care within our state and the potential for being part of the health care team providing chronic disease management programs. Unfortunately, the Health Professions Resource Center (HPRC) was only able to compile data on a limited group of health professionals due to the lack of available resources. Therefore for the current document, the HPRC will be unable to add comparable data for inclusion in Chapter 2 and Appendix C. The SHCC recommends that the HPRC consider adding respiratory therapists to the list for future reports.

Finally, we have included a concept paper for Chronic Obstructive Pulmonary Disease (COPD) including public education in pulmonary health, chronic obstructive pulmonary disease, and smoking cessation, which the Council might wish to include in **Appendix B, Primary Care White Papers**.

SHCC Response: COPD White Paper added to Primary Care White Papers in Appendix.

VI. Texas Silver Hair Legislator

Comments:

1. Overview: Needs to include every six year in-service for Commission/Council Members.

2. Page 2. subchapter A 104.001, b, 1…appropriate health planning activities must include ethnicity and cultural considerations.

3. Page 5. Training 104.0113, a, 1…Program for training of council shall be written, developed and managed by a group of Health Care Providers as those described in item 104.011..composition of council.

4. Page 7. Subchapter C. 104.022, f, 1…strategies for correction of major deficiencies in service deliveries must include two (2) subset definitions:

a. Major

b. Minor

Each subset must have weighted penalties, time period for correction, repeat offenders, publication of offenses

associated with type of event.

5. Page 9. 104.0421 Data Collection C. Agencies/facilities, in order to participate shall have a plan for staff credentialing, development, incentivizing, counseling and appreciation.

6. Page 10. 104.043 Civil Penalty b, Shall be severe and range from fine of not more than $500 per day but can lead to loss of Medicare/Medicaid funds for the time period required for corrections.

7. Page 11. 105.004 Health Professional Resource Center. Reports, 4, Credentialing Program to be in place for checking authenticity, experience and reliability in Health Professionals across all disciplines and those with whom contracting.

8. If not somewhere else included: As a requirement for certification and/or re-certification of health care professional, training in issues related to aging.

SHCC Response: The comments submitted above relate to the statutory authority of the SHCC and not to the *2005-2010 Texas State Health Plan.* However, the SHCC has addressed many of the sections referenced in the comments within the document.

VII. Board of Nurse Examiners

Comments:

General Workforce Recommendations

Recommendation 1:

The BNE supports the concept of the minimum data set developed by the SHCC; however, the BNE requests that agencies be adequately funded to expand or update existing data bases and amend applications, both paper and online, to support collection of this data.

SHCC Response: No change recommended.

Recommendation 3

The BNE does not agree with the recommendation that "the Legislature realign health workforce licensure and regulatory agencies in a structure that is better able to coordinate health workforce planning and data collection." The BNE does not disagree with the concept that agencies collaborate with other stakeholders on workforce planning; and, most agencies are putting forth resources to work with planning groups. The structure of health professions regulatory agencies with the use of the Health Professions Council as an administrative mechanism to coordinate cooperation among the boards is currently designed to balance a number of regulatory service delivery needs that is of a great benefit to Texans.

The structure/alignment of the licensing boards does not pose a barrier to the ongoing work of health workforce planning and data collection. The Council has maintained for years that its member agencies support the concept of the minimum data set. The member agencies simply do not have the funding to develop and maintain the minimum data set.

Changing the alignment/structure of the agencies would not create new funding. In fact, it could cause disruption to a system, which has suffered from budget cuts and possibly further cripple the effort to create the minimum data set.

SHCC Response: No change recommended.

Recommendation 4:

The BNE supports the concept of identifying barriers/implementing solutions to the collection of ethnicity data for health professionals and applicants to health education programs. The BNE points out that the implementation of collection of ethnicity data may likely require legislation to require licensees and applicants to disclose ethnicity information and allow agencies to collect, compile and report it.

SHCC Response: Revise recommendation to include this reference/requirement.

Recommendation 9:

The BNE supports legislation that would allow boards to permit exceptions to their regulations for demonstration projects if, in the judgement of each independent board, the public safety is not jeopardized.

SHCC Response: No action is required. Patient safety is clearly a priority of the SHCC's concerning the intent of this recommendation.

Nursing Workforce Recommendations

Recommendation 3:

The BNE supports the concept of legislation that would enable the member agencies to incorporate the use of technology to reduce paperwork and streamline the process required by regulatory agencies to that which is truly necessary for quality patient care. The BNE agrees with the concept of using technology to streamline the licensure process.

The BNE and Health Professions Council is concerned that the undertone of this recommendation is that agencies and boards currently impose unnecessary requirements on applicants for licensure. Regulatory boards have the responsibility of ensuring that the

standards for licensure are set at a minimum so that persons licensed to deliver health care services in the state of Texas are qualified to do so.

SHCC Response: No change recommended.

5. The BNE supports the concept of interdisciplinary education. The THEBC is offering innovation grants for nursing programs which may require exemptions from our rules for "pilot programs" under the authority of the NPA. It may be helpful to APN programs to share faculty. It would be consistent with the Board's policy position and proposed rule that APNs be prepared more broadly for entry into practice.

SHCC Response: No action required.

6. The Board of Nurse Examiners already permits educational institutions to add appropriate accelerated degree programs at all levels of nursing. We believe that implementation of these programs needs to be studied to assure that educational preparation is not compromised. This is particularly a concern with regard to programs which prepare Advanced Practice Nurses. The independent nature and risk to patient safety of these practitioners requires the depth of didactic and clinical preparation to be sufficient.

SHCC Response: No action required.

7. The Texas Board of Nurse Examiners permits educational institutions to use alternative methods such as the use of technology, preceptors, simulation, etc. to increase the clinical faculty to student ratio while still ensuring quality outcomes. BNE rules permit preceptors and teaching assistants for these purposes.

SHCC Response: No action required.

VIII. Coalition for Nurses in Advanced Practice

Comments:

The Coalition for Nurses in Advanced Practice (CNAP) appreciates the opportunity to comment on the draft of the State Health Plan. We think the text and recommendations in the plan are excellent. We only have a few comments on Chapter 1.

On page 13, in the first paragraph, seventh line, "nursing midwifery" should be changed to "nurse midwifery".

SHCC Response: Changed as recommended.

On page 22, at the end of the first sentence of the third paragraph, CNAP suggests reinforcing the increasing importance of telehealth, by adding an additional phrase at the end of that sentence. We also suggest a few editorial changes. We suggest that sentence read, "In future models, establishing the initial diagnosis, developing the treatment plan, and prescribing medications would probably occur similarly to current models, except these activities will occur much more frequently using technologies such as telehealth."

SHCC Response: Changed as recommended.

On page 24, the number of nurse practitioners is cited for the year 2002, while numbers for PAs and family physicians use 2003 data. If you wish to make the years consistent, the BNE has the number of NPs, as of 9/1/03, posted on its website as 5160. Also, at the end of that paragraph, SHCC recommends that the professions work toward a coordinated workforce. We think it would be more effective to suggest that the state of Texas work for a coordinated plan for the primary care workforce. If left only to the professions, with no pressure from the state, a coordinated plan is unlikely to ever be developed.

SHCC Response: The HPRC utilized 2003 state-level data for this report. The numbers differ from those on the BNE website due to adjustments made by HPRC staff to make the numbers more accurately reflect the number of professionals actually working as nurse practitioners. Deductions are made for those indicating that they are not working in nursing and for those recognized nurses who have indicated they work in other areas such as administration, etc. Staff believes that the adjusted numbers are more accurate as a basis for workforce planning.

Staff was unable to locate the text on page 24 that referenced the coordinated plan for the primary care workforce.

On page 32, the third dot point in recommendation #10 does not indicate what providers should be reimbursed at 92% of the physician's rate. We suggest the following language, "increasing Medicaid and Children's Health Insurance Program reimbursement for advanced practice nurses to 92 percent of the physician's rate."

SHCC Response: Changed as recommended.

On page 32, recommendation #12 is an excellent recommendation, but before state agencies can take action to change regulations to allow NPs, CNSs, and PAs to order home health, federal law must be changed. We suggest rewording recommendation #12 to read, "Texas should direct its Office of State and Federal Relations to encourage federal legislation that allows Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants to order home health care services, and then change state regulations accordingly."

SHCC Response: Changed as recommended.

IX. East Texas Area Health Education Center

Comments:

Thanks for the opportunity to respond to the draft SHCC 2005-2010 State Health Plan. Please note my comments as follows: I am disappointed that Area Health Education Centers (AHECs) are not mentioned in the workforce development and planning discussions, particularly in the dialog on recruitment and retention. The work of the three AHECs covering the state is most commonly defined by their efforts at recruitment and retention, both at the student/candidate level, and at the entering/retained active health professional level.

SHCC Response: Section added on role of the AHECs.

General Workforce Recommendation 8 could easily include identification of continued state support of its three AHECs as an important means for the state to continue to provide vital health careers pipeline development efforts among other recruitment and retention strategies that are not provided through any other means or agency effort.

SHCC Response: Specific recommendation was included in the *2003-2004 Texas State Health Plan Update,* which is the current workforce planning document. Due to the important role that the AHECs play in recruitment and retention of health professionals, the following will be added to General Workforce Recommendation: *The Legislature should support funding of the Area Health Education Centers to guarantee that vital health career development efforts and recruitment and retention strategies are available in areas not provided through other means or agency efforts.*

While there are other areas that could incorporate AHEC recognition, these two are the most important. Thanks for your consideration.

SHCC Response: No additional action recommended.

X. Texas Hospital Association

Comments:

On behalf of the 420 institutional members of the Texas Hospital Association, we are pleased to provide the following comments regarding the draft of the 2005-2010 State Health Plan developed by the Texas Statewide Health Coordinating Council. THA appreciates the opportunities over the past year to provide input during the development of the draft plan at numerous stakeholder meetings, as well as SHCC subcommittee and council meetings.

THA is pleased that the draft State Health Plan identifies the nursing shortage as one of the most critical health workforce issues. Addressing the nursing shortage is one of THA's top five priorities. The recommendations cited in the draft plan addressing nursing recruitment, retention and education mirror recommendations in THA's Health Care Workforce Strategic Plan. THA supports the plan of action and recommendations presented by the SHCC to alleviate not only the current, but also the anticipated future nursing shortage.

SHCC Response: No action required.

THA also appreciates the draft State Health Plan's consideration of a redesigned health care delivery system for the future. The Association is committed to improving the overall health status of Texans and identifying strategies to enhance chronic disease management. THA supports the primary care recommendations as proposed, but asks the SHCC to provide additional clarification regarding the Federally Qualified Health Centers and the reimbursement for care provided under Medicaid and the Children's Health Insurance Program.

SHCC Response: Clarification added on the 92% reimbursement section to "add advanced practice nurse" as the referenced provider.

THA requests that Primary Care Recommendation #7 emphasize the need for FQHCs to increase their hours of service by offering evening hours on week days and providing services on the weekends. Extending hours will ensure increased access to health care and

help offset the inappropriate use of hospital emergency departments. Also, THA requests clarification of Primary Care Recommendation #10 regarding increasing the Medicaid/ CHIP reimbursement to 92 percent of the physician's rate. Please insert the name of providers to whom this recommendation applies.

SHCC Response: The recommendation to expand the FQHC hours of operations goes beyond the level of "broad policy recommendations".

Primary Care Recommendation #10 changed to include the name of the referenced provider, advanced practice nurse.

Again, THA supports, with the minor clarifications noted above, the recommendations listed in the draft State Health Plan and thanks the SHCC for including THA in this important state health care process.

XI. Center for South Texas Programs

Comments:

I appreciate the opportunity to review the draft of the 2005-2010 Texas State Health Plan that will serve as a guide to help Texas leaders formulate appropriate health workforce policy.

After reviewing the plan, I felt disappointed that after over a decade of operating the Area Health Education Center (AHEC) of South Texas, no mention of Area Health Education Centers were mentioned in the draft report. AHECs are charged with the mission of improving the number, distribution, and quality of health professional manpower, especially in MUAs and HPSAs. While operating under federal funds through Title VII of the Public Health Service Act, AHECs also receive state, foundation, and private funding to maintain and expand their services.

Texas has three operating AHECs – East Texas based at the University of Texas Medical Branch; South Texas based at the University of Texas Health Science Center at San Antonio; and West Texas based at Texas Tech Health Science Center in Lubbock. The exclusion of these important programs from the Texas State Health Plan is not understandable to me, especially given the length of time AHECs have operated in Texas and the many contributions they have made to many TDH activities, conferences, and meetings.

It seems it would be advantageous for the citizens of this state if the Texas State Health Plan identifies the need for continuing state support for the AHECs as one of the means of addressing the maldistribution, recruitment, and retention of health professionals in underserved areas and to support student pipeline program activities such as our HCOP and MED-ED programs in South Texas which are duplicated by our sister AHECs in other regions of the state.

I would appreciate your consideration to include the federal/state AHEC programs as a component of this report.

SHCC Response: Section added on role of the AHECs.

XII. Texas Dental Association

Comments:

On behalf of the Texas Dental Association (TDA), we would like to offer our comments on the draft 2005–2010 Texas State Health Plan. First, we would like to express TDA's general support for the Plan, as well as our appreciation for the time and effort that members and staff of the Statewide Health Coordinating Council devoted to developing it. We are also pleased that Dr. Richard M. Smith of Amarillo, a TDA member, recently joined the Council and was able to contribute to the plan.

Our comments about specific aspects of the plan follow.

General Workforce Recommendations

Recommendation 5. The Legislature and the Texas Higher Education Coordinating Board should develop and implement positive financial incentives for schools that create innovative models in education for the health professions that will move toward shared or combined curricula, interdisciplinary classes across health programs, and the use of multi-disciplinary faculty or interdisciplinary teams among the health programs. (p. 28)

TDA Comment: The "innovative models in education for the health professions" addressed in this recommendation should conform to state law and professional regulatory board rules regarding scope of practice. Efforts in this area should consider workforce projections for the dental profession and base curriculum recommendations on both short- and long-term implications for patient access.

SHCC Response: No action required.

Recommendation 9. The Legislature should direct the regulatory boards for the health professions to permit exceptions to their regulations to facilitate the increase in innovative, outcome-oriented demonstration projects. (p. 29)

TDA Comment: This recommendation should not be construed to authorize or encourage regulatory boards for the health professions to circumvent state law governing scope of practice.

SHCC Response: The SHCC encourages regulatory boards to support collaboration to foster evidence-based outcomes and research.

Primary Care Recommendations

Recommendation 7. The Legislature should continue to support the increase in the numbers of Federally Qualified Health Centers in Texas. (p. 31)

TDA Comment: Efforts to expand the number of Federally Qualified Health Centers should be directed by current data regarding Health Professional Shortage Areas and coordinated with local dentists to preserve and protect existing dental care systems and dentist-patient relationships.

SHCC Response: No action required.

Recommendation 8. The Legislature should support methodologies for the development of innovative models for the delivery of primary care that would include physical, mental, and oral health. (p. 31)

TDA Comment: TDA is pleased that this recommendation specifically includes "oral health," recognizing the importance of prevention and early treatment of oral disease as part of overall health maintenance and promotion.

SHCC Response: No action required.

Recommendation 10. The Legislature should support changes in Medicaid, Children's Health Insurance Program, and Texas Vendor Drug Program rules and policies to trace outcomes and increase accountability by

- identifying the practitioner that prescribed the drug instead of the delegating physician,

- requiring all providers to bill services under their own names, and

- increasing Medicaid and Children's Health Insurance Program reimbursement to 92 percent of the physician's rate. (p. 32)

TDA Comment: This recommendation apparently refers to policy positions developed through a collaborative effort by the medical, nursing, and physician assistant professions. We believe that it warrants further clarification.

SHCC Response: Clarification added relating to the 92% reimbursement to reference "advanced nurse practitioner".

Recommendation 14. The Legislature will provide positive financial incentives for providers who implement the use of evidence-based health care and the use of outcome-based practice guidelines that have been approved by an agreed upon nationally recognized health association. (p. 32)

TDA Comment: TDA supports the use of evidence-based oral health care and would add that outcome-based practice guidelines should reflect the standard of care upheld by each profession.

SHCC Response: No action required.

Appendix B, Primary Care Models

Finally, TDA would like to briefly comment on two white papers included in Appendix B of the draft Plan:

- **"The School Dental Hygienist,"** proposed by Dr. Chris French Beatty of the Texas Dental Hygiene Educators' Association (pp. 16-17), and

- **"Health Promotion Specialists: School Based Oral Health Program,"** proposed by Ms. Andrea Scott of the Texas Dental Hygienists' Association (pp. 18-20).

TDA Comment: Under both proposals, dental hygienists would provide educational services, preventive treatment, and dental referrals in the public schools. Current state law already allows dental hygienists to provide all of those services in public schools under the general supervision of a dentist. The two proposals go farther, however, by advocating the amendment of state law and agency rules to permit dental hygienists to practice unsupervised and to bill Medicaid and private insurers for their services. TDA believes that eliminating the dentist's responsibility for authorizing and supervising care provided by dental hygienists is unwarranted and ill-advised.

Current state law properly recognizes that dental hygienists do not have the education and training required to properly diagnose dental diseases, disorders, or physical conditions. Moreover, in our professional experience, individuals who do not receive regular oral health care usually require extensive restorative treatment that only a dentist can provide.

Given the likely absence of state funding and the ongoing budget pressures faced by local school districts, neither of the proposals would be cost-effective. Existing teachers and school nurses can (and likely already do) provide oral health education as part of their schools' health curriculum. In addition, both proposals would require public schools to hire staff and acquire costly equipment that would duplicate resources already available in local dental offices, clinics, or community health centers.

SHCC Response: The White Papers included in Appendix B are not subject to change by the SHCC.

XIII. Texas Workforce Commission

Comments:

We submit the following comments for consideration in the *State Health Plan*:

1. Address the potential resources available from the public workforce system, specifically the Local Workforce Development Boards (Boards). In 2000, Governor Perry made nursing one of three state's targeted occupations. The Commission and the Boards launched several initiatives across the state that focused on the nursing shortage. These initiatives included recruiting and training efforts using the Boards' formula funds, state discretionary funds, and federal funds (notably

federal H-1B grants). Unfortunately, the SHCC *State Health Plan* has no reference to the Boards' role in developing the health care workforce.

SHCC Response: Reference added per above recommendation.

2. Make recommendations that include public-private cooperation to address healthcare workforce shortages. Public incentives can be available not only to state agencies and colleges, but also to hospitals and to other healthcare organizations. The *State Health Plan* does briefly describe initiatives by other groups that appear to be addressing the public-private arena, but it does not appear to be a focus of the *Health Plan*.

SHCC Response: See final paragraph of TWC comments below. No additional action required.

3. Provide greater emphasis on the "retention" or "attrition" problem among the nursing workforce. The growing inability to retain nurses contributes as much to the nursing shortage as the inability to retain teachers contributes to the teacher shortage. The "retention" problem is almost wholly a function of inadequate salaries and an inhospitable workplace. During the past three years recognition of these conditions has brought attention and some improvement, but there is yet a long way to go.

SHCC Response: No action recommended. However, the Texas Workforce Commission could develop a partnership with the Area Health Education Centers for health care recruitment and retention and for development of a program for recruitment and retention of entry-level positions into the health profession's pipeline.

The *State Health Plan* provides a very good, fact-based, foundation for describing the problems of the healthcare workforce and forecasts of the likely decreasing quality of healthcare unless that workforce increases in number and quality. It appears that the research and collaboration concerning these issues was extensive.

SHCC Response: No response necessary.

The Texas Institute for Health Policy Research (TIHPR) is undertaking the "Shared Vision for Health Care in Texas" project. This effort may obviate one of the shortcomings noted

above-the failure to address opportunities for public-private cooperation because the Institute will involve " a forum for dialogue among leaders of Texas' health care providers, payers, and consumers for informed decision making." On August 17, 2004, the SHCC and the Institute will co-host the first Shared Vision Policy Forum in Austin. The Commission would like to commend SHCC on your cooperation with TIHPR.

SHCC Response: No response necessary.

XIV. Texas Department of State Health Services-Community Preparedness Section

Comments:

Workforce issues are a concern throughout health care. The plan addresses the issues thoroughly from a global perspective. In today's environment, workforce issues are a significant concern in identifying personnel that are capable, and willing, to respond to disasters that result from the effects of weapons of mass destruction.

There should be some consideration of the impact terrorism will have on the workforce of health professionals. When fundamental change in the system is discussed, one cannot ignore the impact an act of terrorism. First is the impact on the response. A certain number of health professionals will be victims of the attack or limited in their mobility as a result of an attack. Second is the impact of the disaster on the responder. A certain percentage of the health care workforce are not going to be willing to place themselves in immediate danger with the possibility of exposing their families to the danger.

There were two studies looking at the response by health professionals to acts involving weapons of mass destruction and large-scale biological events. The Hawaii Medical Personnel Assessment: A Longitudinal Study conducted by S. Lanzilotti, EdD, that addressed availability of nurses and physicians to staff non-hospital, field medical facilities for mass casualty incidents resulting from the use of weapons of mass destruction and the level of knowledge and skills these personnel possessed related to the treatment of victims. The emphasis was no one ever asked will the health care professionals come and, if they do, will they know what to do. The findings showing response to natural disasters, explosions, chemical attacks, biological attacks, nuclear/radiological attacks and large-

scale contagious epidemics was dramatic. There were 84% of the nurses said they would respond to a natural disaster. The numbers dropped with each type of event until only 49% would respond to a large-scale contagious disease outbreak. This has definite workforce implications when a response to a disaster is needed.

I think we were remiss in identifying priority issues for the *2003-2004 Update* by not including the impact of the terrorist events of 2001 and the efforts in planning and preparedness from a health care workforce perspective. Terrorism and the Health Care Workforce should be included as a priority area. The increased demand for registered nurses in the acute care setting will only be complicated by the exponential increase in the face of a large-scale disaster that results from and act of terrorism.

The role of primary care is another area that needs to be addressed from a response perspective. The role needs to be defined in relation to a response to an act of terrorism. Primary care is a resource and will be involved in an event. The profession needs to be involved in the regional planning efforts and preparing themselves to fulfill their identified role.

The anticipation of another attack on the US has never been higher. The demands placed on health care to provide the necessary emergency care will be unlike anything the US has ever experienced. The preparedness efforts have brought health care and public health a long way toward an appropriate response. One area that has been in the forefront and a concern at all levels is the capacity and capability of the health care workforce. This issue should be a concern in the health plan and be an area that has continued emphasis and direction from the Department of State Health Services as a voice of health care in the state.

SHCC Response: Additional references added as requested.

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

September 16, 2004

Ben G. Raimer, M.D., Chair
Statewide Health Coordinating Council
110 West 49th Street
Austin, TX 78758-3199

Dear Dr. Raimer:

The Health and Human Services Commission is pleased to submit this letter of support for the Statewide Health Coordinating Council's 2005-2010 Texas State Health Plan.

The SHCC is to be commended for its continued focus in the areas education and training in the health professions that will ensure that an appropriately skilled, sufficient, and experienced workforce becomes a reality for the state. The SHCC is to be particularly congratulated for its emphasis on the examination of innovative models of education and practice. Successful implementation of the recommendations in the plan will be a significant step towards improving access to quality health care.

HHSC looks forward to continuing to work in partnership with the SHCC especially on potential policy and rule changes in Medicaid, Children's Health Insurance Program, and Texas Vendor Drug Programs that support the goals of the 2005-2010 Texas State Health Plan. We look forward to working with the SHCC towards the vision of a healthier Texas.

Sincerely,

Rick Allgeyer, Ph.D., Director
Center for Strategic Decision Support
Texas Health and Human Services Commission

Connie Turney

From: Silverman, Stacey [Stacey.Silverman@THECB.state.tx.us]
Sent: Thursday, July 29, 2004 11:53 AM
To: Connie Turney
Subject: Proposed changes to TSHP recommendations

State Health Plan -- proposed ...

Hi Connie,

After reviewing the revised recommendations for the State Health Plan, I have consulted with my colleagues and drafted some additional changes. These changes are primarily for clarification purposes.

Please let me know if you have any questions.

Best regards,
Stacey

Stacey Silverman, MA
Program Director
Texas Higher Education Coordinating Board
1200 East Anderson Lane
Austin, Texas 78752
Phone 512.427.6206
Fax 512.427.6168
Email stacey.silverman@thecb.state.tx.us

State Health Plan

Proposed revisions to current recommendations:

Nursing Workforce Recommendations:

2. The Legislature should continue to support the Nursing Innovation Grant Program funded by tobacco earnings from the Permanent Fund for Higher Education Nursing, Allied Health, and Other Health-Related Programs and administered by the Texas Higher Education Coordinating Board.

4. The Legislature should provide institutions with Special Item funding to support enrollment increases in nursing programs and stimulate graduate programs that prepare nursing faculty, and establish procedures that would confirm that these special allocations for nursing programs are spent for these purposes.

8. The Texas Higher Education Coordinating Board and the Texas Board of Nurse Examiners should encourage institutions to use technology, preceptors, simulation, etc., to maximize the use of existing and new faculty, while ensuring quality outcomes and increasing student enrollments.

Primary Care:

Add a new recommendation regarding pharmacy education; it could be placed between current recommendations 6 and 7.

The Legislature should provide Special Item funding to support enrollment increases at the state's pharmacy schools to help relieve the current shortage of pharmacists in the state.

6. The Legislature should increase funding levels for the Physician Education Loan Repayment Program by mandating that all Texas medical schools that receive state funds participate in the "two percent set aside."

Connie Turney

From: Richard Hoeth [rhoeth@tha.org]
Sent: Tuesday, August 03, 2004 11:38 AM
To: Elizabeth Sjoberg
Cc: Connie Turney
Subject: FW: IMPORTANT Health Data Website

Follow Up Flag: Follow up
Flag Status: Flagged

Elizabeth and Connie, I finally had a chance to review this, and also plan on attending the meeting on August 17th. However, here are the manpower shortages I am still hearing about in the rural areas:

1. Primary care physicians...They can't find enough of them to meet the needs. Internal medicine is becoming more scarce, and OB/GYNs scarcer still, unless one already is in practice in the rural community seeking to recruit another. This makes sense, when you consider the scope and 24 hour responsibility of an OB physician's practice.

2. Nursing is still an issue, although for now most rural hospitals have increased salaries, benefits, and improved working conditions to be competitive with urban areas. Urban areas keep upping the ante. The problem will become exacerbated as more nurses retire in years to come, and as the nursing instructors continue to age and retire. Then, we will have the issue flare up badly again.

3. Next hot area: CRNA's....very hard to find in rural areas, and if they can be found, they are becoming increasingly unaffordable.

4. Radiology techs, and especially ultrasonagraphers, very hard to find in some rural areas.

5. Pharmacists are also becoming harder to find, and as rural pharmacists retire, the "sticker-shock" of replacing them with staff requiring retail pharmacist's salaries (now in the triple digits) is tough on rural hospitals. (Some rural CEOs still do not make triple digit salaries!)

6. Mental health workers....any category, are hard to recruit/retain in rural areas.

7. Dentist and dental technicians are in short supply in rural areas, which in many parts of the state, lack dental staff to maintain oral health.

To the extent the SHCC can address those staffing areas in rural areas, it will be very beneficial to our rural members and the rural citizens they serve.

Richard

-----Original Message-----
From: Connie Turney [mailto:Connie.Turney@tdh.state.tx.us]
Sent: Thursday, July 29, 2004 9:18 AM
To: Allison, Jane S.; Anderberg, Marc; Andrews, Claude L.; Bartos, Justin; Berry, Connie; Berryhill, Becky; Camarillo, Barry; Rosa Campos; Coleridge, Timothey D.O.S.; Cooper, Curtis; Cornish, Cindy; Cortez, Leslie; Edwards, Debra; Fair, Christy; Fitzsimmons, Dana S.; Ford, Betty; Foxhall, Lewis E.; Furino, Antonio; Gipson, Ronnie; Gleasman,

August 6, 2004

ConnieTurney,
Texas Statewide Health Coordinating Council
1100 West 49th Street
Austin, Texas 78756

Dear Ms Turney,

The Consortium of Texas Certified Nurse Midwives (CTCNM) fully supports the focus of the 2005-2010 Texas State Health Plan on having competent health professionals strategically placed in the health care delivery system. We are pleased that under the Nursing Workforce Recommendations, an increase in funding levels to nursing programs is included. Under the Primary Care Recommendations, you have 5 recommendations, which address financial support for medical education programs and their students. The importance of physician providers to a health care delivery system is universally understood.

CTCNM urges your consideration of the contribution of certified nurse midwives to our health care system. Nurse midwives have demonstrated that they are competent health professionals who can safely provide many of the same services as OB/GYN physicians. In health settings, they have improved access to care by increasing the provider pool and by freeing physicians to focus on high-risk patients. As the enclosure demonstrates, numerous studies on nurse-midwifery care consistently report good outcomes with associated cost savings. In addition, nurse-midwifery educational programs are shorter and less expensive than medical educational programs.

Unfortunately, within the last year, two nurse-midwifery educational programs have stopped admitting new students. Currently there is only one educational program remaining within the state. Given the proven value of this group of professionals, we urge you to expand your recommendations to include increasing funding specifically for educational settings that provide nurse midwifery educational programs.

Please contact me if I can provide additional information about nurse-midwifery in Texas

Sandra Gale, CNM
Legislative Liaison
Consortium of Texas Certified Nurse Midwives

Attachments: CNM's Contribution to Health Care

Sandra Gale CNM, FNP, MPH, MSN
6806 Terra Oak Circle ∃ Austin ∃Texas ∃78749
512-892-3429 ∃Fax: 512-892-4338
Email: gale@jnfohwy.com

Sandra Gale CNM, FNP, MPH, MSN
6806 Terra Oak Circle ∃ Austin ∃Texas ∃78749
512-892-3429 ∃Fax: 512-892-4338
Email: gale@infohwy.com

In the case of ADVANCED PRACTICE NURSES, less is more.
A focused, less expensive educational process results in
HIGH VALUE PROVIDERS.

CERTIFIED NURSE MIDWIVES (CNMs)
CONTRIBUTIONS TO HEALTH CARE

Where midwifery care is offered, CNMs reduce costs by:

- lowering the c-section rate, therefore reducing patient complications and prolonged hospital stays;
- reducing premature births, therefore reducing neonatal ICU admissions and neonatal mortality rates; and
- avoiding excessive testing and unnecessary technological interventions.

CNMs increase access to maternal health care by:

- providing care to medically underserved populations;
- freeing physicians to focus on problem pregnancies and deliveries; and
- offering care in a variety of settings that reduce costs and shorten stays.

References

CNMs lower cesarean section rate

The obstetric outcomes of a primary-care clinic for low-income women staffed by certified nurse-midwives supervised by a private practice group of four obstetricians, compared with the obstetric outcomes of that physician group's private practice patients, showed comparable birth outcomes with a significant reduction in cesarean sections (13.1% to 26.4%) for CNMs' patients. [Source: Bianchette H. (1995). Comparison of obstetric outcome of a primary-care access clinic staffed by certified nurse-midwives and a private practice group of obstetricians in the same community. American Journal of Obstetrics & Gynecology, 172, 1864-1868.]

Obstetricians, family physicians, and certified nurse-midwives differed in patterns of obstetric care provided to low-risk patients in Washington State. Certified nurse-midwives were less likely to induce or augment labor and use continuous electronic fetal monitoring or epidural anesthesia. The cesarean section rate for patients of certified nurse-midwives was 8.8% vs. 13.6% for obstetricians and 15.1% for family physicians. CNMs used 12.2% fewer resources. [Source: Rosenblatt RA, Dobie SA, Hart LG, Schneeweiss R, Gould D, & Raine TR (1997). Interspecialty differences in the obstetric care of low-risk women. American Journal of Public Health, 87, 344-351.]

Women cared for by nurse-midwives in a Chicago Hospital had a lower cesarean section rate (8.5% vs. 12.9%), fewer interventions, and equally good maternal and infant outcomes when compared with those cared for by physicians. [Source: Davis LG; Riedmann GL; Sapiro M; Minogue JP; Kazer RR (1994). Cesarean section rates in low-risk private patients managed by certified nurse-midwives and obstetricians. J Nurse Midwifery, 39, 91-97.]

CNMs provide quality care at a lower cost

Low-risk patients receiving collaborative midwifery care had birth success rates comparable to those who saw physicians, with fewer interventions, more options, and lower cost to the health care system. [Source: Jackson, J.L., Lang, J.M., Swartz, W.H., Ganiats, T.G., Fullerton, J., & Ecker, J. (2003). Outcomes, safety, and resource utilization in a collaborative care birth center program compared with traditional physician-based perinatal care. American Journal of Public Health, 93, 999-1006.]

After controlling for social and medical risk factors, the risk of experiencing an infant death was 19% lower for certified nurse midwife attended births than physician attended births. The risk of delivering a low birthweight infant was 31% lower. Mean birthweight was 37 grams heavier for CNM attended than for physician attended births. The authors, from the Centers for Disease Control and Prevention, National Center for Health Statistics, conclude that national data support findings of previous local studies that certified nurse midwives have excellent birth outcomes, and CNMs provide a safe and viable alternative to maternity care in the United States, particularly for low to moderate risk women. [Source: MacDorman, M.F., Singh, G.K. (1998). Midwifery care, social and medical risk factors, and birth outcomes in the USA. J Epidemiology & Community Health, 52, 310-317.]

Pregnancy outcomes were compared for 710 women cared for by private obstetricians and 471 cared for by certified nurse-midwives to determine whether pregnancy outcomes differ by provider group when alternative explanations are taken into account. CNM care resulted in fewer third or fourth degree lacertions (23% vs 7%), fewer complications (0.7 vs. 0.4%), more infants remaining with mother for the entire hospital stay (15% versus 27%), and greater satisfaction with care. [Source: Oakley D; Murray ME; Murtland T; Hayashi R; Andersen HF; Mayes F; Rooks J. (1996). Comparisons of outcomes of maternity care by obstetricians and certified nurse-midwives. Obstetrics & Gynecology, 88, 823-829.]

The Department of Defense utilizes certified nurse midwives (CNMs) for the delivery of primary women's health care. Although the numbers of CNMs remain relatively small, their impact on quality, cost, choice, and access to care is substantial. CNMs are not merely physician extenders, but primary health providers who emphasize holistic and wellness-oriented care. [Source: Davis, L.J. (1995). Certified nurse midwives: over twenty years of military service. Military Medicine, 160, 401-404.]

The Medical University of South California Twin Clinic study demonstrated a lower rate of very early pre-term births, very low birthweight infants, Neonatal intensive care admissions, and perinatal mortality in a CNM directed Clinic where CNM care is given when compared to a MD directed team where MD care is given. This demonstrated that the contributions of CNMs to high-risk prenatal care can be considerable. [Source: Ellings & Janna, et al. (1993). Certified-nurse midwife directed twin clinic reduces very low birthweight delivery & perinatal mortality. Journal of Obstetrics and Gynecology]

The quality of CNM care is equivalent to physicians' care within their area of competence, according to a 1986 study by the Office of Technology Assessment. Further, they are better than physicians at providing services which depend on communication with patients and preventive action. [Source: Department of Health & Human Services, Office of Inspector General " A Survey of Certified Nurse-Midwives," March 1992, p. F-2.]

At two HMO centers when CNMs were added to the obstetrical teams, there was a 13% or $292,000 reduction in payroll costs at one center and a 7% or $2 million reduction at another center. [Source: Bell, K., & Mills, J. I. (1989). Certified nurse-midwife effectiveness in health maintenance organization team. Obstetrics and Gynecology, 74, 112-116.]

If only 50% of 4,060,000 births were attended in free-standing birth centers (run by midwives), not only would access to care be greatly improved but savings would be almost $4 billion annually. (Source: National Association of Childbearing Centers Survey Report Experience 1987-1989.)

CNMs care for underserved populations

CNMs care for medically underserved women and those at higher risk for poor outcomes, including women who are uninsured (16%), immigrant (27%), adolescent (29%), and women of color (50%). [Source: Declercq ER, Williams DR, Koontz AM, Paine LL, Streit EL, & McCloskey L (2001). Serving women in need: nurse-midwifery practice in the United States. Journal of Midwifery & Women's Health 46, 11-6.]

Connie Turney

From:	SUE PICKENS [SPICKE@parknet.pmh.org]
Sent:	Friday, August 06, 2004 2:56 PM
To:	connie.turney@tdh.state.tx.us
Cc:	JENNIFER CUTRER; RON ANDERSON
Subject:	comments on the 2005-2010 State Health Plan

Thanks so much for allowing a comment period on the the 2005-2010 State Health Plan. Parkland would like to make the following comments:

The Higher Education Coordinating Board is currently conducting a study of the state's support of Graduate Medical Education. There are two interim committies, one in each chamber, that is reviewing the consequences of the Legislature's elimination of GME funding in the 78th Session. Preliminary reports indicate that there is a $380 million shortfall for 67% of the residents in teaching hosipitals. It is strongly recommended that the work of the HECB and the findings of the two legislative committees be given high priority by the 79th Legislature. The retention of residency slots assure that doctors have a tendency to stay in the state that helps fund residencies. Current shortages of doctors in underserved areas and the looming shortfall of doctors in urban and rural areas must be addressed in the immediate future.

If you have any questions regarding this comment, please do not hesitate to contact me.

Sue Pickens

Sue Pickens
Director Strategic Planning and Population Medicine
5201 Harry Hines Blvd
Dallas, Texas 75235
Phone 214-590-8067
Fax 214-590-5958
Pager 214-786- 8348

Connie Turney

From: Wagner, Roy [ROY.WAGNER@tenethealth.com]
Sent: Monday, August 09, 2004 9:37 AM
To: connie.turney@tdh.state.tx.us
Subject: Comments on "2005-2010 Texas State Health Plan Draft"

August 9, 2004

Texas Department of Health
Center for Health Statistics
ATTN: Connie Turney, SHCC Project Director
1100 West 49th Street
Austin, Texas 78756

Ms. Turney:

On behalf of the Texas Society for Respiratory Care (TSRC), a statewide professional association representing several thousand respiratory therapists, I appreciate the opportunity to comment on the proposed 2005-2010 Texas State Health Plan developed by the Statewide Health Coordinating Council.

The Texas Society for Respiratory Care advocates for respiratory patients and strives to assure that our patients receive appropriate respiratory care services delivered by competent practitioners. We recognize and promote the value of respiratory therapy and Respiratory Care Practitioners in all areas of pulmonary health and public policy.

Respiratory care practitioners care for patients of all ages who suffer from respiratory illness such as asthma, emphysema, chronic obstructive pulmonary disease (COPD- the 4th leading cause of death in the United States). Respiratory therapists are on the front lines caring for patients suffering from tuberculosis, and most recently treating patients who were afflicted with Severe Acute Respiratory Syndrome (SARS). Respiratory therapists care for patients across all care sites, from the hospital to the home to the nursing home and to the physician office.

The TSRC is concerned that the Draft document does not recognize, nor include data and information, on the profession of respiratory care even though our profession has an integral and growing role in providing non acute care services to the people of Texas, such as asthma disease management and smoking cessation counselors, two important public health issues facing all states.

The Texas Society for Respiratory Care respectfully requests the final version of the 2005-2010 Texas State Health Plan include information and data for the respiratory care practitioner in sections:

Chapter 2, "Status of the Health Workforce in TX under the Allied Health Profession".
Appendix B: Primary Care White Papers
Appendix C: Health Workforce Data.

As an attachment we have included more detailed information on the respiratory care practitioner in Texas obtained from the United States Health Resources and Services Administration (HRSA) database.

Finally, we have included a concept paper for Chronic Obstructive Pulmonary Disease (COPD) including public education in pulmonary health, chronic obstructive pulmonary disease, and smoking

cessation, which the Council might wish to include in **Appendix B, Primary Care White Papers**.

The TSRC will be happy to assist the Council to obtain further information as needed to fit into the format of the Draft plan.

The TSRC appreciates your time and consideration. Please see attachments and to assure that you received all data, please e-mail me a response of reception.

Roy E. Wagner, RCP, RRT
Delegate
Texas Society for Respiratory Care
EMail: roy.wagner@tenethealth.com
Phone (469)893-2859
Fax (469)893-3859

RESPIRATORY THERAPY

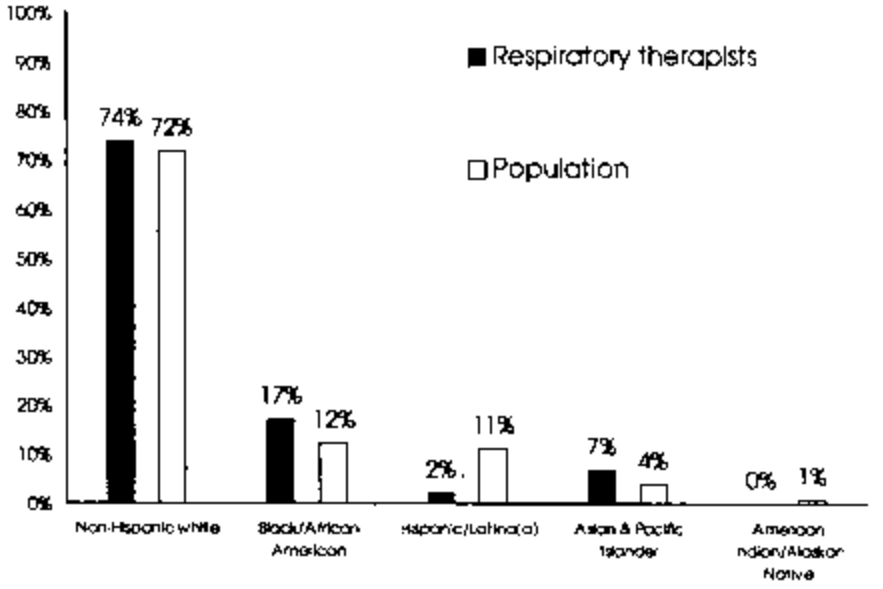
- √ There were 6,120 respiratory therapists in practice in Texas in 1998.
- √ There were 31 respiratory therapists per 100,000 population, close to the national average of 31.4. Texas ranked 25th in the nation in respiratory therapists per capita.
- √ The majority of respiratory therapists in the United States were non-Hispanic white and female.
- √ The number of respiratory therapy technician graduates in the United States declined 19% between 1991-92 and 1996-97 while the total population grew 5%. The result was a 23% decline in respiratory therapy graduates per capita nationwide.
- √ In 1996-97, 65.7% of respiratory therapy technician degree recipients in Texas were non-Hispanic white, compared to 56.7% in the general population. Twenty-one percent were Hispanic/Latino, compared to 28.5% in the general population.

Respiratory therapists, 1998

	Texas	Region VI	US	Rank
Respiratory therapists	6,120	10,140	84,730	2/50
Per 100,000 population	31.0	32.0	31.4	25/50
Percent female	-	-	61%	-

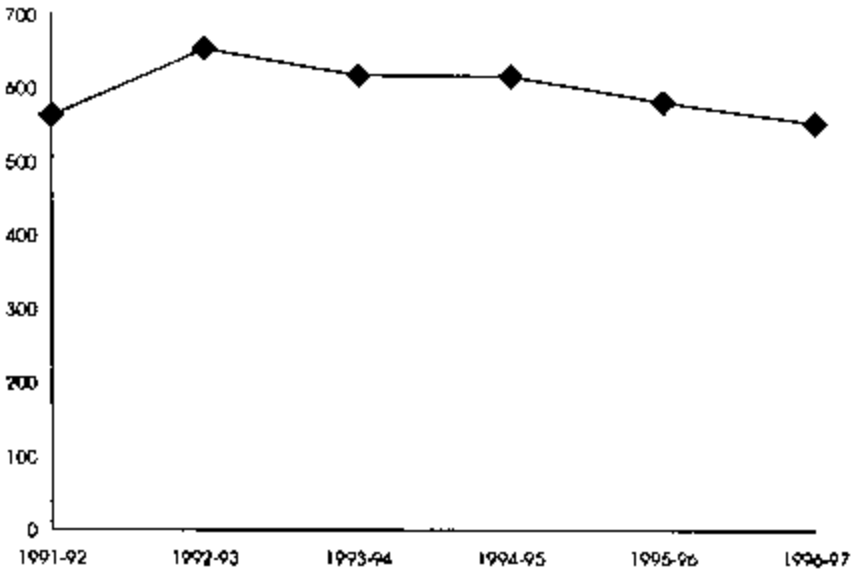
Source: Bureau of Labor Statistics; Bureau of the Census.

Race/ethnicity of respiratory therapists & the population, U.S., 1999



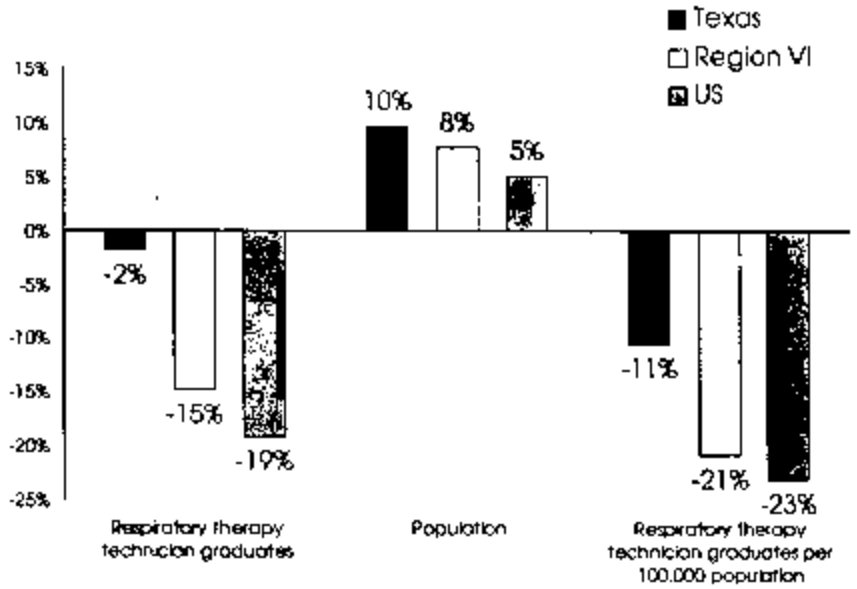
Source: Bureau of Labor Statistics; Bureau of the Census.

Respiratory therapy technician degrees awarded, 1992-3 to 1996-7



Source: National Center for Education Statistics.
Note: Includes the "respiratory therapy technician" major field of study extant in the data.

Percentage change in respiratory therapy technician graduates, population & respiratory therapy technician graduates per 100,000 population, 1991-92 to 1996-97



Source: National Center for Education Statistics; Bureau of the Census.
Note: Includes the 'respiratory therapy technician' major field of study extant in the data.

Race/ethnicity & gender of respiratory therapy technician degree recipients & the population, 1996-97

	Respiratory therapy technician education program degree recipients	Population
Race/ethnicity		
Non-Hispanic white	65.7%	56.7%
Black/African American	8.5%	11.7%
Hispanic/Latino(a)	20.7%	28.5%
Asian & Pacific Islander	4.9%	2.7%
American Indian/Alaskan Native	0.2%	0.5%
Total	100.0%	100.0%
Gender		
Female	67.6%	50.8%
Male	32.4%	49.2%
Total	100.0%	100.0%

Source: National Center for Education Statistics; Bureau of the Census.
Note: Includes the 'respiratory therapy technician' major field of study extant in the data.

Innovative Primary Care Models to Improve Access and Outcomes

Caryn Pope, RRT, RCP
Roy Wagner, RRT, RCP
Texas Society for Respiratory Care
Dallas TX972- 495-9200

Title: The Respiratory Care Practitioner and the COPD Patient

Respiratory Care Practitioners (RCP) are a distinct profession dating back to the1930's. During each of the seventy-plus years of working with patients with lung disease, no group has potentially benefited more than those with Chronic Obstructive Lung Disease (COPD). Initially, RCPs simply provided oxygen to this patient while hospitalized, usually via an oxygen tent or face mask. But during these seven decades of improved equipment, medication and monitoring the RCP has become not only the provider of respiratory therapy but the most qualified educator for this chronically ill population.

COPD is a major cause of chronic morbidity and mortality throughout the state of Texas. It ranks as the fourth leading cause of death in the United States. Further, due to the aging population increases in the prevalence and mortality of the disease can be predicted in the coming decades. A unified effort of education, research and treatment is required to reverse this trend.

Recently the World Health Organization issued the following statement regarding tobacco use: "Current projections show a rise of 31 % in tobacco-related deaths during the next twenty years, which will double the current death toll, bringing it to almost ten million a year," said WHO Director-General Dr LEE Jong-wook to countries attending the Intergovernmental Working Group.

It is the belief of this group that the state of Texas could be the leader in the United States to form throughout the state COPD education groups with its essential tobacco cessation program. This could save the state of Texas millions of dollars in Medicaid expenditures over the next few years.

COPD is a disease state where airflow is limited and no medication will fully reverse that condition. The airflow limitation is usually both progressive and associated with an abnormal response to noxious particles or gases. The diagnosis of COPD should be considered in any patient who has symptoms of cough, sputum production, or shortness of breath and/or a history of exposure to risk factors for the disease. The diagnosis can be confirmed by pulmonary function testing. All physicians are being encouraged to perform simple spirometry on their patients who exhibit the above symptoms. Once even a

diagnosis of even mild COPD is made the patient would be referred to the RCP for education and monitoring.

The purpose of ongoing patient education groups is to allow the COPD patient to learn more about the disease. It has been well documented in peer-reviewed literature that ongoing education of the patient about the disease process improves outcomes. The program would consist not only of education regarding disease management and expectations but also a very important component of smoking cessation. It is estimated that over 50% of patients diagnosed with COPD continue to use tobacco.

COPD patient education groups are scattered, at best, throughout the state. Although there are several very successful groups, these tend to be located in the larger metropolitan areas, sponsored by hospital-based respiratory care departments. The goal of this COPD program would be to provide both group education as well as ongoing support education via DVD and/or the internet.

In 1981, the American Thoracic Society gave its first Statement on the efficacy and scientific foundation of pulmonary rehabilitation programs. Since then it has become firmly established that strategies employed by pulmonary rehabilitation programs are now an integral part of the clinical management and health maintenance of patients with COPD who remain symptomatic or continue to have decreased function despite standard medical management. Since pulmonary rehabilitation programs are not available in all areas of the state, we propose that respiratory care practitioners provide a COPD education program including a tobacco education segment.

How will your model improve outcomes without increasing health care cost?
The patients enrolled in these programs are those who would most benefit from it. Prevalence and morbidity data greatly underestimate the total burden of COPD because the disease is usually not diagnosed until it is clinically apparent and moderately advanced.

What process is in place to collect and analyze process and outcome measures?
The program is developed to collect outcome measures. Patients not actively attending group education classes will be contacted via telephone or internet as to well-being and other outcome measures (e.g., ER visits, hospitalizations, unscheduled physician visits, non-routine prescriptions).

Does your model emphasize standard treatment protocols (evidence-based practice guidelines and patient instruction and reinforcement concerning self care?
It is noted throughout the literature that those patients who have improved knowledge of their disease, exposures that trigger exacerbation utilize fewer healthcare services. An effective COPD management plan includes four components:

1. Assessment and monitoring;
2. Reduction of Risk Factors;
3. Management of Stable COPD and;
4. Management of Exacerbations.

The goals of effective COPD management include: prevention of disease progression, relief of symptoms, improvement in exercise tolerance, improve health status, prevent and treat complications, prevent and treat exacerbations and reduce mortality. The Global Initiative for Chronic Obstructive Lung Disease or GOLD Book defines the global strategy for the diagnosis, management and prevention of COPD. This book is the executive summary of the NHLBI/WHO workshop.

How will this model be used to create a "wellness" model rather than an "illness" model?
This program would emphasize the prevention of COPD through the tobacco cessation segment. Since it is known that passive exposure to cigarette smoke may also contribute to respiratory symptoms and COPD by increasing the lung's total burden of inhaled particulates and gases, tobacco cessation classes should be able to reduce this exposure.

Smoking during pregnancy may also pose a risk for the fetus, by affecting lung growth and development of the fetus. It would be suggested that upon determination of pregnancy, a tobacco-using female should be referred to a smoking cessation program.

What effect will your model have on the demand for health workforce in the future?
The model would utilize respiratory care practitioners acting on the referral of a physician, physician's assistant or nurse practitioner. The state currently has an adequate number of RCPs to provide the work force.

How will the community be utilized to improve the health of the community?
Communities will be involved through use of community social programs promoting and setting up smoking cessation classes and offer continuing support for their citizens through open communication, public service announcements and publication of success stories. Additionally, we could train and develop laypeople for this through a training program. The community is involved by placing the program within the hospitals and/or medical centers. Other healthcare providers would become more aware of the program, encouraging and reinforcing participation. Involvement of community leaders by disallowing smoking in public buildings would help to empower the community and the participants in tobacco cessation.

How will your model improve the culturally sensitive delivery of healthcare?
All cultures develop COPD, all cultures use tobacco. Many materials are now available in English, Spanish and Vietnamese.

How will your model improve health disparities and access to care?
With successful education in the four components of education the COPD patient will need less emergent care, less hospitalization and decreased physician office visits.

How does or how could technology be utilized to improve the effectiveness of your primary care delivery model in terms of outcomes or cost?
Once patients are evaluated by the RCP for understanding of the program and the program is implemented, much of the outcomes monitoring and ongoing education and information could be done via mail or internet.

What are the barriers to implementing your model?
Currently, the numbers of programs are very limited and physicians do notreadily refer patients to COPD education programs and smoking cessation programs. If programs were available at the majority of community hospitals and/or medical centers in an ongoing or rotating basis, patients would have much improved access.

What regulatory/legislative/reimbursement issues will be required to implement or expand your model?
Reimbursement for patient education would be necessary for this population as it is for the patient with diabetes. Thus changes in reimbursement regulations would be required.

Connie Turney

From: Ann Pennington [apennington2@austin.rr.com]

Sent: Monday, August 09, 2004 3:01 PM

To: connie.turney@tdh.state.tx.us

Cc: 'Maryalice Craig'; 'Barbara Effenberger'; 'Betty Streckfuss'; 'Carlos Higgins'; 'Charlotte Parks'; 'Chris Kyker'; 'Fannie Lovelady Spain'; 'Glen Peterson'

Subject: Comments on 2005-2010 Texas State Health Plan

Dear Ms. Turney:

The following are comments prepared by Texas Silver Hair Legislators, Ann Pennington and Betty Streckfuss. Thank you for your consideration.

1. Overview: Needs to include every six year in-service for Commission/Council Members.
2. Page 2. subchapter A 104.001, b, 1...appropriate health planning activities must include ethnicity and cultural considerations.
3. Page 5. Training 104.0113, a, 1...Program for training of council shall be written, developed and managed by a group of Health Care Providers as those described in item 104.011..composition of council.
4. Page 7. Subchapter C. 104.022, f, 1...strategies for correction of major deficiencies in service deliveries must include two (2) subset definitions:
   a. Major
   b. Minor

   Each subset must have weighted penalties, time period for correction, repeat offenders, publication of offenses associated with type of event.

5. Page 9. 104.0421 Data Collection C: Agencies/facilities, in order to participate shall have a plan for staff credentialing, development, incentivizing, counseling and appreciation.
6. Page 10. 104.043 Civil Penalty b, Shall be severe and range from fine of not more than $500 per day but can lead to loss of Medicare/Medicaid funds for the time period required for corrections.
7. Page 11. 105.004 Health Professional Resource Center. Reports, 4, Credentialing Program to be in place for checkitg authenticity, experience and reliability in Health Professionals across all disciplines and those with whom contracting.
8. If not somewhere else included: As a requirement for certification and/or re-certification of health care professional, training in issues related to aging.

Thank you for your consideration. Please feel free to call either of us if you have questions.

Ann Pennington
Texas Silver Hair Legislator
3600 Indian Point Drive
Austin, TX 78739
512/282-7708
apennington2@austin.rr.com

Betty Streckfuss
Texas Silver Hair Legislator
3704 Blue Candle
Spring, TX 77388
281/350-9136
streckfuss2@msn.com

Connie Turney

From: KATHY THOMAS [KATHY.THOMAS@BNE.STATE.TX.US]
Sent: Monday, August 09, 2004 5:08 PM
To: 'connie.turney@tdh.state.tx.us'
Subject: SHCC Health Plan

Connie, Attached are comments on the Health Plan. We have not really had sufficient time to flesh out the fiscal impact but would appreciate opportunity to do that after the close of comments today. Let me know if that is possible.

Kathy

Katherine A. Thomas, MN, RN
Executive Director Board of Nurse Examiners for the State of Texas, and
Chair of the Health Professions Council

Board of Nurse Examiners' response to the draft 2005-2010 State Health Plan

General Workforce Recommendations

Recommendation 1:

The BNE supports the concept of the minimum data set developed by the SHCC; however, the BNE requests that agencies be adequately funded to expand or update existing data bases and amend applications, both paper and online, to support collection of this data.

Recommendation 3

The BNE does not agree with the recommendation that "the Legislature realign health workforce licensure and regulatory agencies in a structure that is better able to coordinate health workforce planning and data collection." The BNE does not disagree with the concept that agencies collaborate with other stakeholders on workforce planning; and, most agencies are putting forth resources to work with planning groups. The structure of health professions regulatory agencies with the use of the Health Professions Council as an administrative mechanism to coordinate cooperation among the boards is currently designed to balance a number of regulatory service delivery needs that is of a great benefit to Texans.

The structure/alignment of the licensing boards does not pose a barrier to the ongoing work of health workforce planning and data collection. The Council has maintained for years that its member agencies support the concept of the minimum data set. The member agencies simply do not have the funding to develop and maintain the minimum data set. Changing the alignment/structure of the agencies would not create new funding. In fact, it could cause disruption to a system, which has suffered from budget cuts and possibly further cripple the effort to create the minimum data set.

Recommendation 4:

The BNE supports the concept of identifying barriers/implementing solutions to the collection of ethnicity data for health professionals and applicants to health education programs. The BNE points out that the implementation of collection of ethnicity data may likely require legislation to require licensees and applicants to disclose ethnicity information and allow agencies to collect, compile and report it.

Recommendation 9:

The BNE supports legislation that would allow boards to permit exceptions to their regulations for demonstration projects if, in the judgement of each independent board, the public safety is not jeopardized.

Nursing Workforce Recommendations

Recommendation 3:

The BNE supports the concept of legislation that would enable the member agencies to incorporate the use of technology to reduce paperwork and streamline the process required by regulatory agencies to that which is truly necessary for quality patient care. The BNE agrees with the concept of using technology to streamline the licensure process.

The BNE and Health Professions Council is concerned that the undertone of this recommendation is that agencies and boards currently impose unnecessary requirements on applicants for licensure. Regulatory boards have the responsibility of ensuring that the standards for licensure are set at a minimum so that persons licensed to deliver health care services in the state of Texas are qualified to do so.

5. The BNE supports the concept of interdisciplinary education. The THEBC is offering innovation grants for nursing programs which may require exemptions from our rules for "pilot programs" under the authority of the NPA. It may be helpful to APN programs to share faculty. It would be consistent with the Board's policy position and proposed rule that APNs be prepared more broadly for entry into practice.

7. The Board of Nurse Examiners already permits educational institutions to add appropriate accelerated degree programs at all levels of nursing. We believe that implementation of these programs needs to be studied to assure that educational preparation is not compromised. This is particularly a concern with regard to programs which prepare Advanced Practice Nurses. The independent nature and risk to patient safety of these practitioners requires the depth of didactic and clinical preparation to be sufficient.

8. The Texas Board of Nurse Examiners permits educational institutions to use alternative methods such as the use of technology, preceptors, simulation, etc. to increase the clinical faculty to student ratio while still ensuring quality outcomes. BNE rules permit preceptors and teaching assistants for these purposes.

Connie Turney

From: Lynda Freed Woolbert [mwoolb@charter.net]
Sent: Tuesday, August 10, 2004 8:21 AM
To: 'Connie Turney'
Subject: CNAP Comments on State Health Plan

Texas Department of Health
Center for Health Statistics
ATTN: Connie Turney, SHCC Project Director
1100 West 49th Street
Austin, Texas 78756

The Coalition for Nurses in Advanced Practice (CNAP) appreciates the opportunity to comment on the draft of the State Health Plan. We think the text and recommendations in the plan are excellent. We only have a few comments on Chapter 1.

On page 13, in the first paragraph, seventh line, "nursing midwifery" should be changed to "nurse midwifery".

On page 22, at the end of the first sentence of the third paragraph, CNAP suggests reinforcing the increasing importance of telehealth, by adding an additional phrase at the end of that sentence. We also suggest a few editorial changes. We suggest that sentence read, "In future models, establishing the initial diagnosis, developing the treatment plan, and prescribing medications would probably occur similarly to current models, except these activities will occur much more frequently using technologies such as telehealth."

On page 24, the number of nurse practitioners is cited for the year 2002, while numbers for PAs and family physicians use 2003 data. If you wish to make the years consistent, the BNE has the number of NPs, as of 9/1/03, posted on its website as 5160. Also, at the end of that paragraph, SHCC recommends that the professions work toward a coordinated workforce. We think it would be more effective to suggest that the state of Texas work for a coordinated plan for the primary care workforce. If left only to the professions, with no pressure from the state, a coordinated plan is unlikely to ever be developed.

On page 32, the third dot point in recommendation #10 does not indicate what providers should be reimbursed at 92% of the physician's rate. We suggest the following language, "increasing Medicaid and Children's Health Insurance Program reimbursement for advanced practice nurses to 92 percent of the physician's rate."

On page 32, recommendation #12 is an excellent recommendation, but before state agencies can take action to change regulations to allow NPs, CNSs, and PAs to order home health, federal law must be changed. We suggest rewording recommendation #12 to read, "Texas should direct its Office of State and Federal Relations to encourage federal legislation that allows Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants to order home health care services, and then change state regulations accordingly."

Thank you for considering these comments. If you have any questions, please contact me by any of the methods below.

Lynda Woolbert, MSN, RN, CPNP
CNAP Director of Public Policy
(979) 345-5974

8/10/2004

Connie Turney

From: Shelton, Steve R. [srshelto@utmb.edu]
Sent: Monday, August 09, 2004 6:25 PM
To: Connie Turney
Cc: Raimer, Ben G.; Wainwright, Mary E.; pam.danner@ttuhsc.edu; Richard Garcia (Garcia, Richard)
Subject: RE: Public Comment Period Announcement

Thanks for the opportunity to respond to the draft SHCC 2005-2010 State Health Plan. Please note my comments as follows:

I am disappointed that Area Health Education Centers (AHECs) are not mentioned in the workforce development and planning discussions, particularly in the dialog on recruitment and retention. The work of the three AHECs covering the state is most commonly defined by their efforts at recruitment and retention, both at the student/candidate level, and at the entering/retained active health professional level.

General Workforce Recommendation 8 could easily include identification of continued state support of its three AHECs as an important means for the state to continue to provide vital health careers pipeline development efforts among other recruitment and retention strategies that are not provided through any other means or agency effort.

While there are other areas that could incorporate AHEC recognition, these two are the most important. Thanks for your consideration.

Steve Shelton
409.772.7884

-----Original Message-----
From: Connie Turney [mailto:Connie.Turney@tdh.state.tx.us]
Sent: Tuesday, July 20, 2004 5:08 PM
To: Al Holguin (E-mail); Alice K. Marcee (E-mail); Amy Lindley (E-mail);
Subject: Public Comment Period Announcement
Importance: High

Texas Health Workforce Stakeholders-

The Texas Statewide Health Coordinating Council (SHCC) announces the public
comment period for the 2005-2010 Texas State Health Plan Draft. Under Chapter 104 of the Health and Safety Code, the SHCC is mandated to develop a
six-year State Health Plan with biennial updates. The plan serves as a guide to help Texas leaders formulate appropriate health workforce policy.
The 2005-2010 Texas State Health Plan is the initial document in a new six-year planning cycle. The draft document will be posted for the period
from July 21, 2004 through August 9, 2004. It will be available for viewing
and downloading on the SHCC website at http://www.TexasSHCC.org for review
by the public. We ask that requests for copies be made only by those individuals who do not have access to the Internet. Those requests should
be addressed to the following:

Texas Department of Health
Center for Health Statistics
ATTN: Connie Turney, SHCC Project Director
1100 West 49th Street
Austin, Texas 78756
(512) 458-7111, Ext. 3548 - Telephone request
(512) 458-7344 - Fax request
connie.turney@tdh.state.tx.us
<mailto:connie.turney@tdh.state.tx.us>
- Email request

The SHCC will consider written comments on the document that are postmarked,
faxed, or emailed no later than August 10, 2004. These comments should be
sent to the attention of Connie Turney, SHCC Project Director at the address
noted above or by email at connie.turney@tdh.state.tx.us
<mailto:connie.turney@tdh.state.tx.us>.

Please do not hesitate to contact me should you require additional information or clarification.

Connie Turney
Project Director
Texas Statewide Health Coordinating Council
connie.turney@tdh.state.tx.us
(512) 458-7111, Ext. 3548 (Voice)
(512) 458-7344 (Fax)

Center for Health Statistics, Texas Department of Health
...The Portal for Comprehensive Health Data in Texas
www.tdh.state.tx.us/chs

East Texas Area Health Education Center (AHEC)
2002-2003 Accomplishments

Health Workforce Development - Health Careers Promotion

- Provided careers information to 35,237 career-decision makers, 93% from under-represented minorities and disadvantaged populations.
- Provided 103 enrichment projects with 29,036 hours of programming to better prepare 2,244 students, 94% from under-represented minorities and disadvantaged populations, for health professions education programs.
- Worked with 528 primary and secondary schools to facilitate health career awareness through classroom, peer, teacher, and counselor support activities and informational materials.

Health Workforce Development - Community-Based Education

- Recruited and/or maintained 468 community-based training sites and 749 community faculty, primarily physicians, for student clinical training.
- Placed 1,296 health professions students for 110,991 training hours for 18 disciplines from 40 campus partners.
- Supported the utilization of 50 laptop and 30 desktop computers for training in community settings to enhance information resources.

Health Workforce Development - Practice Entry and Support

- Offered 157 continuing education programs totaling 630 course hours to 7,505 participants.
- Increased partnership activity in retention of health professionals, including 10 new projects.
- Co-sponsored satellite programming throughout the region.
- Expanded and maintained learning resource materials and dissemination of information for community health professionals.
- Identified 255 (cumulative) health professionals added to our region after an "AHEC Touch."

Community Health Support – Health Literacy

- Increased health education programming through 535 projects/programs to 28,171 participants.
- Maintained programs addressing community health issues such as geriatric sensitivity, tobacco cessation, domestic violence, and cancer awareness.

Community Health Support – Community Health Systems

- Expanded capacity for conducting community assessment and community development activities.
- Initiated 55 community health system support projects, such as, a structured process designed to involve community members in developing ways to improve local health care delivery systems and community health status.

Developing Organization Infrastructure

- Maintained 9 operational centers to service an area of 111 counties with an estimated population of 17 million.
- Partnered with communities and academic collaborators, including all 8 of the state's health science centers/schools of medicine and over 1,100 organizations and institutions.
- Leveraged $2,126,769 in state funds for $1,490,441 in Federal funds and $580,500 in other grant and contracts funds with over $3,500,000 in value of in-kind services provided.

East Texas AHEC
301 University Boulevard, Route 1056
Galveston, Texas 77555-1056
Tel: (409) 772-7884 Fax: (409) 772-7885

TEXAS HOSPITAL ASSOCIATION

August 9, 2004

Connie Turney, Project Director
Texas Statewide Health Coordinating Council
1100 West 49th Street
Austin, Texas 78756

e-mailed to: connie.turney@tdh.state.tx.us

RE: 2005-2010 Texas State Health Plan Draft, Texas Statewide Health Coordinating Council

Dear Ms. Turney:

On behalf of the 420 institutional members of the Texas Hospital Association, we are pleased to provide the following comments regarding the draft of the 2005-2010 State Health Plan developed by the Texas Statewide Health Coordinating Council. THA appreciates the opportunities over the past year to provide input during the development of the draft plan at numerous stakeholder meetings, as well as SHCC subcommittee and council meetings.

THA is pleased that the draft State Health Plan identifies the nursing shortage as one of the most critical health workforce issues. Addressing the nursing shortage is one of THA's top five priorities. The recommendations cited in the draft plan addressing nursing recruitment, retention and education mirror recommendations in THA's Health Care Workforce Strategic Plan. THA supports the plan of action and recommendations presented by the SHCC to alleviate not only the current, but also the anticipated future nursing shortage.

THA also appreciates the draft State Health Plan's consideration of a redesigned health care delivery system for the future. The Association is committed to improving the overall health status of Texans and identifying strategies to enhance chronic disease management. THA supports the primary care recommendations as proposed, but asks the SHCC to provide additional clarification regarding the Federally Qualified Health Centers and the reimbursement for care provided under Medicaid and the Children's Health Insurance Program.

THA requests that Primary Care Recommendation #7 emphasize the need for FQHCs to increase their hours of service by offering evening hours on week days and providing services on the weekends. Extending hours will ensure increased access to health care and help offset the inappropriate use of hospital emergency departments. Also, THA requests clarification of Primary Care Recommendation #10 regarding increasing the Medicaid/CHIP reimbursement to 92 percent of the physician's rate. Please insert the name of providers to whom this recommendation applies.

Again, THA supports, with the minor clarifications noted above, the recommendations listed in the draft State Health Plan and thanks the SHCC for including THA in this important state health care process.

Sincerely,

Elizabeth N. Sjoberg, RN, J.D.
Associate General Counsel

Jennifer C. Banda, J.D.
Director, Government Affairs

Center for South Texas Programs
UTHSCSA

The University of Texas Health Science Center at San Antonio

Mail Code 7839 • 7703 Floyd Curl Drive • San Antonio, Texas 78229-3900 • (210) 567-7813 • FAX: (210) 567-7820

August 9, 2004

Transmitted via E-Mail

Connie Turney
Project Director
Texas Statewide Health Coordinating Council
1100 West 49th Street
Austin, Texas 78756

Dear Ms. Turney,

I appreciate the opportunity to review the draft of the 2005-2010 Texas State Health Plan that will serve as a guide to help Texas leaders formulate appropriate health workforce policy.

After reviewing the plan, I felt disappointed that after over a decade of operating the Area Health Education Center (AHEC) of South Texas, no mention of Area Health Education Centers were mentioned in the draft report. AHECs are charged with the mission of improving the number, distribution, and quality of health professional manpower, especially in MUAs and HPSAs. While operating under federal funds through Title VII of the Public Health Service Act, AHECs also receive state, foundation, and private funding to maintain and expand their services.

Texas has three operating AHECs – East Texas based at the University of Texas Medical Branch; South Texas based at the University of Texas Health Science Center at San Antonio; and West Texas based at Texas Tech Health Science Center in Lubbock. The exclusion of these important programs from the Texas State Health Plan is not understandable to me, especially given the length of time AHECs have operated in Texas and the many contributions they have made to many TDH activities, conferences, and meetings.

It seems it would be advantageous for the citizens of this state if the Texas State Health Plan identifies the need for continuing state support for the AHECs as one of the means of addressing the maldistribution, recruitment, and retention of health professionals in underserved areas and to support student pipeline program activities such as our HCOP and MED-ED programs in South Texas which are duplicated by our sister AHECs in other regions of the state.

I would appreciate your consideration to include the federal/state AHEC programs as a component of this report.

Sincerely,

Richard A. Garcia, MHA
Assistant Vice President for South Texas Programs

Connie Turney

From: Jay [jbond@tda.org]
Sent: Tuesday, August 10, 2004 4:50 PM
To: connie.turney@tdh.state.tx.us
Subject: Comments on Draft 2005-2010 State Health Plan

Comments on
005-2010 State He.

Dear Ms. Turney,

Please see the attached letter RE: TDA Comments on Draft State Health Plan.

Jay Bond
Director of Policy
Texas Dental Association
1946 S. IH-35, Suite 400
Austin, Texas 78704
(512) 443-3675 Ext. 133 Fax: (512) 443-3031
jbond@tda.org
Pager: 512-399-7474
email to Pager: 5123997474@airmessage.net

August 6, 2004

Ms. Connie Turney, SHCC Project Director
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756

Dear Ms. Turney:

On behalf of the Texas Dental Association (TDA), we would like to offer our comments on the draft 2005–2010 Texas State Health Plan. First, we would like to express TDA's general support for the Plan, as well as our appreciation for the time and effort that members and staff of the Statewide Health Coordinating Council devoted to developing it. We are also pleased that Dr. Richard M. Smith of Amarillo, a TDA member, recently joined the Council and was able to contribute to the plan.

Our comments about specific aspects of the plan follow.

General Workforce Recommendations

Recommendation 5. The Legislature and the Texas Higher Education Coordinating Board should develop and implement positive financial incentives for schools that create innovative models in education for the health professions that will move toward shared or combined curricula, interdisciplinary classes across health programs, and the use of multi-disciplinary faculty or interdisciplinary teams among the health programs. (p. 28)

TDA Comment: The "innovative models in education for the health professions" addressed in this recommendation should conform to state law and professional regulatory board rules regarding scope of practice. Efforts in this area should consider workforce projections for the dental profession and base curriculum recommendations on both short- and long-term implications for patient access.

Recommendation 9. The Legislature should direct the regulatory boards for the health professions to permit exceptions to their regulations to facilitate the increase in innovative, outcome-oriented demonstration projects. (p. 29)

TDA Comment: This recommendation should not be construed to authorize or encourage regulatory boards for the health professions to circumvent state law governing scope of practice.

Primary Care Recommendations

Recommendation 7. The Legislature should continue to support the increase in the numbers of Federally Qualified Health Centers in Texas. (p. 31)

TDA Comment: Efforts to expand the number of Federally Qualified Health Centers should be directed by current data regarding Health Professional Shortage Areas and coordinated with local dentists to preserve and protect existing dental care systems and dentist-patient relationships.

Recommendation 8. The Legislature should support methodologies for the development of innovative models for the delivery of primary care that would include physical, mental, and oral health. (p. 31)

TDA Comment: TDA is pleased that this recommendation specifically includes "oral health," recognizing the importance of prevention and early treatment of oral disease as part of overall health maintenance and promotion.

Recommendation 10. The Legislature should support changes in Medicaid, Children's Health Insurance Program, and Texas Vendor Drug Program rules and policies to trace outcomes and increase accountability by

- identifying the practitioner that prescribed the drug instead of the delegating physician,
- requiring all providers to bill services under their own names, and
- increasing Medicaid and Children's Health Insurance Program reimbursement to 92 percent of the physician's rate. (p. 32)

TDA Comment: This recommendation apparently refers to policy positions developed through a collaborative effort by the medical, nursing, and physician assistant professions. We believe that it warrants further clarification.

Recommendation 14. The Legislature will provide positive financial incentives for providers who implement the use of evidence-based health care and the use of outcome-based practice guidelines that have been approved by an agreed upon nationally recognized health association. (p. 32)

TDA Comment: TDA supports the use of evidence-based oral health care and would add that outcome-based practice guidelines should reflect the standard of care upheld by each profession.

Appendix B, Primary Care Models

Finally, TDA would like to briefly comment on two white papers included in Appendix B of the draft Plan:

- **"The School Dental Hygienist,"** proposed by Dr. Chris French Beatty of the Texas Dental Hygiene Educators' Association (pp. 16-17), and

- **"Health Promotion Specialists: School Based Oral Health Program,"** proposed by Ms. Andrea Scott of the Texas Dental Hygienists' Association (pp. 18-20).

TDA Comment: Under both proposals, dental hygienists would provide educational services, preventive treatment, and dental referrals in the public schools. Current state law already allows dental hygienists to provide all of those services in public schools under the general supervision of a dentist. The two proposals go farther, however, by advocating the amendment of state law and agency rules to permit dental hygienists to practice unsupervised and to bill Medicaid and private insurers for their services. TDA believes that eliminating the dentist's responsibility for authorizing and supervising care provided by dental hygienists is unwarranted and ill-advised.

Current state law properly recognizes that dental hygienists do not have the education and training required to properly diagnose dental diseases, disorders, or physical conditions. Moreover, in our professional experience, individuals who do not receive regular oral health care usually require extensive restorative treatment that only a dentist can provide.

Given the likely absence of state funding and the ongoing budget pressures faced by local school districts, neither of the proposals would be cost-effective. Existing teachers and school nurses can (and likely already do) provide oral health education as part of their schools' health curriculum. In addition, both proposals would require public schools to hire staff and acquire costly equipment that would duplicate resources already available in local dental offices, clinics, or community health centers.

Thank you for considering the Texas Dental Association's comments on these important issues.

Sincerely,

S. Jerry Long, D.D.S.
Chair, TDA Council on Legislative and Regulatory Affairs

Texas Workforce Commission

Member of the Texas Workforce Network

August 9, 2004

Ms. Connie Turney, SHCC Project Director
Texas Department of Health
Center for Health Statistics
1100 West 49th Street
Austin, Texas 78756

Dear Ms. Turney:

Thank you for providing the Texas Workforce Commission (Commission) with the opportunity to comment on the Texas Statewide Health Coordinating Council's (SHCC) draft of the *2005-2010 Texas State Health Plan (State Health Plan)*. The Commission is especially pleased that the SHCC continues to focus on the needs of the Texas healthcare workforce.

The Commission supports many of the recommendations outlined in the *State Health Plan*, specifically:

- Improving coordination among colleges that train the healthcare workforce;
- Improving coordination among licensing authorities;
- Increased salaries for faculties, especially nursing faculties;
- Enabling the increased use of technology to train the healthcare workforce; and
- Pursuing opportunities to obtain federal funding for healthcare workforce training and education.

We submit the following comments for consideration in the *State Health Plan*:

1. Address the potential resources available from the public workforce system, specifically the Local Workforce Development Boards (Boards). In 2000, Governor Perry made nursing one of three state's targeted occupations. The Commission and the Boards launched several initiatives across the state that focused on the nursing shortage. These initiatives included recruiting and training efforts using the Boards' formula funds, state discretionary funds, and federal funds (notably federal H-1B grants). Unfortunately, the SHCC *State Health Plan* has no reference to the Boards' role in developing the health care workforce.

2. Make recommendations that include public-private cooperation to address healthcare workforce shortages. Public incentives can be available not only to state agencies and colleges, but also to hospitals and to other healthcare organizations. The *State Health Plan* does briefly describe initiatives by other groups that appear to be addressing the public-private arena, but it does not appear to be a focus of the *Health Plan*.

3. Provide greater emphasis on the "retention" or "attrition" problem among the nursing workforce. The growing inability to retain nurses contributes as much to the nursing shortage as the inability to retain teachers contributes to the teacher shortage. The "retention" problem is almost wholly a function of inadequate salaries and an inhospitable workplace. During the past three years recognition of these conditions has brought attention and some improvement, but there is yet a long way to go.

The *State Health Plan* provides a very good, fact-based, foundation for describing the problems of the healthcare workforce and forecasts of the likely decreasing quality of healthcare unless that workforce increases in number and quality. It appears that the research and collaboration concerning these issues was extensive.

The Texas Institute for Health Policy Research (TIHPR) is undertaking the "Shared Vision for Health Care in Texas" project. This effort may obviate one of the shortcomings noted above— the failure to address opportunities for public-private cooperation because the Institute will involve "a forum for dialogue among leaders of Texas' health care providers, payers, and consumers for informed decision making." On August 17, 2004, the SHCC and the Institute will co-host the first Shared Vision Policy Forum in Austin. The Commission would like to commend SHCC on your cooperation with TIHPR.

Again, thank you for the opportunity to comment on the *2005-2010 Texas State Health Plan*. If you have any questions, please contact me at (512) 936-0697.

Sincerely,

Luis M. Macias, Director
Workforce Development Division

mc: Larry E. Temple, Executive Director
H. E. (Gene) Crump, Jr., Deputy Executive Director

2005-2010 Texas State Health Plan

Texas Department of State Health Services - Community Preparedness Section

Review comments:

Workforce issues are a concern throughout health care. The plan addresses the issues thoroughly from a global perspective. In today's environment, workforce issues are a significant concern in identifying personnel that are capable, and willing, to respond to disasters that result from the effects of weapons of mass destruction.

There should be some consideration of the impact terrorism will have on the workforce of health professionals. When fundamental change in the system is discussed, one cannot ignore the impact an act of terrorism. First is the impact on the response. A certain number of health professionals will be victims of the attack or limited in their mobility as a result of an attack. Second is the impact of the disaster on the responder. A certain percentage of the health care workforce are not going to be willing to place themselves in immediate danger with the possibility of exposing their families to the danger.

There were two studies looking at the response by health professionals to acts involving weapons of mass destruction and large-scale biological events. The Hawaii Medical Personnel Assessment: A Longitudinal Study conducted by S. Lanzilotti, EdD, that addressed availability of nurses and physicians to staff non- hospital, field medical facilities for mass casualty incidents resulting from the use of weapons of mass destruction and the level of knowledge and skills these personnel possessed related to the treatment of victims. The emphasis was no one ever asked will the health care professionals come and, if they do, will they know what to do. The findings showing response to natural disasters, explosions, chemical attacks, biological attacks, nuclear/radiological attacks and large-scale contagious epidemics was dramatic. There were 84% of the nurses said they would respond to a natural disaster. The numbers dropped with each type of event until only 49% would respond to a large-scale contagious disease outbreak. This has definite workforce implications when a response to a disaster is needed.

I think we were remiss in identifying priority issues for the 2003-2004 Update by not including the impact of the terrorist events of 2001 and the efforts in planning and preparedness from a health care workforce perspective. Terrorism and the Health Care Workforce should be included as a priority area. The increased demand for registered nurses in the acute care setting will only be complicated by the exponential increase in the face of a large-scale disaster that results from and act of terrorism.

The role of primary care is another area that needs to be addressed from a response perspective. The role needs to be defined in relation to a response to an act of terrorism. Primary care is a resource and will be involved in an event. The profession needs to be involved in the regional planning efforts and preparing themselves to fulfill their identified role.

The anticipation of another attack on the US has never been higher. The demands placed on health care to provide the necessary emergency care will be unlike anything the US has ever experienced. The preparedness efforts have brought health care and public health a long way toward an appropriate response. One area that has been in the forefront and a concern at all levels is the capacity and capability of the health care workforce. This issue should be a concern in the health plan and be an area that has continued emphasis and direction from the Department of State Health Services as a voice of health care in the state.

Texas Statewide Health Coordinating Council
1100 West 49th Street
Austing, Texas 78756-3199
512-458-7261

10/2004 Publication #25-12087